

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is **VOLUNTARY**. However, failure to comply may result in the form not being accepted.

## APPLICATION FOR LICENSURE AND/OR EXAMINATION

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page **APPLICATION FOR LICENSURE AND/OR EXAMINATION**.
2. **INSTRUCTION SHEET**, which gives step by step application instructions for your profession.
3. **REFERENCE SHEET**, which gives detailed coding information for your profession.
4. **SUPPORTING DOCUMENTS**, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit **PROOF OF LEGAL NAME CHANGE** - copy of marriage license, divorce decree, affidavit or court order.

1. Carefully follow all steps outlined on the **INSTRUCTION SHEET**. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. The licensure and application fee are **NOT** refundable.
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-05. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any law administered by the Illinois Department of Revenue.

### A. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME <b>PHYSICIAN</b>	2. PROFESSION CODE <b>1 2 5</b>	3. LICENSURE METHOD <b>NON-EXAMINATION</b>	4. FEE <b>\$ 100.00</b>
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### B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☒ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: \_\_\_\_\_
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new specialty language.

### PART B: Applicant Identification Information (You must provide this information to the Department of Professional Regulation, Illinois State Board of Examiners, 100 North Dearborn Street, Chicago, IL 60610, or to any other designated office.)

1. NAME LAST FIRST MIDDLE <b>Garcia, Anthony Joseph</b>	2. TITLE (e.g., MD, D.D.S., etc.) <b>M.D.</b>	3. UNITED STATES SOCIAL SECURITY NO. _____
---	--	---

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY _____	ZIP CODE _____	COUNTY _____
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY _____	ZIP CODE _____	COUNTY _____
---	-------------------	-----------------

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED (SEE INSTRUCTIONS AS ABOVE) <b>N/A</b>
--

7. PLACE OF BIRTH CITY STATE/COUNTRY _____	8. DATE OF BIRTH ____/____/____	9. AGE ____
--	------------------------------------	----------------

<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Male
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10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
---

Work (____)	Home (____)
-------------	-------------

(AREA CODE) _____	(AREA CODE) _____
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NAME LAST, FIRST, MI

Garcia, Anthony, J.

Physician

## PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12

Graduated

High School?

☒ Yes☐ No

Received

OR G.E.D.?

☐ Yes☒ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED

Walnut High School

3. LAST PRELIMINARY SCHOOL LOCATION (City and State)

Walnut, CA

4. DATE OF GRADUATION

06/1991

Month

Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8

Graduated?

☒ Yes☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)

California State University Los Angeles

LOCATION

(City and State or Country)

Los Angeles, CA

DATES OF ATTENDANCE

FROM

TO

Month/Year

Month/Year

06/92

06/94

TYPE OF DEGREE EARNED

B.S.

University of Utah

Salt Lake City, UT

8/94

5/99

M.D.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME

LOCATION

(City and State or Country)

DATES OF ATTENDANCE

FROM

TO

Month/Year

Month/Year

Did You Complete Training?

Creighton University

Omaha, NE

7/2000

7/2001

☒ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No



**PART IV: Record of Licensure Information**

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
Nebraska	Physician	4214	7/2000	Lapsed
State of Current Licensure where you most recently have been practicing				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

**PART V: Record of Examination**

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step 1	UT	6/97	Failed
USMLE Step 1	CA	10/97	Passed
USMLE Step 2	CA	8/98	Failed
USMLE Step 2	CA	3/99	Passed
USMLE Step 3	CA	2/2000	Passed

(If additional space is needed, attach a separate sheet.)

Garcia, Anthony J.

Physician

**PART VI: Personal History Information (This part must be completed by all applicants)**

- |   | YES | NO |
|---|-----|----|
| 1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.  |     | X  |
| 2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment. |     | X  |
| 3. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.   |     | X  |
| 4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.  |     | X  |

**PART VII: Examination Coding Information (This part is for examination applicants only)**

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

- a) CHART II - Select examination(s) you desire and enter Test Codes.

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- b) CHART III - Select the examination site you desire and enter Test Center Code:

--	--	--	--

- c) CHART IV - Find your School of Graduation and enter school code:

--	--	--	--	--	--	--	--

- d) Record the number of times you have taken this exam in Illinois or any other state:

--	--

- e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated?

Yes ☐ No ☐**PART VIII: Child Support Information (This part must be completed by all applicants)**

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order:

Are you more than 30 days delinquent in complying with a child support order?

(NOTE: If you are not subject to a child support order, answer "No.")

☒ NO ☐ YES

In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.

**PART IX: Certifying Statement**

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Date

7-18-2001

My signature above authorizes the Department of Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.



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**CERTIFICATE OF ACCEPTANCE  
FOR  
SPECIALTY/RESIDENCY PROGRAM**

SUPPORTING DOCUMENT

**CA-MED**

**NOTE:** An applicant shall not commence specialty/residency training before he or she has received written notice of the approval of his application from the Department of Professional Regulation.

**APPLICANT:** Complete the information of this form then forward it to the Department of Professional Regulation for specialty/residency training for consideration.

1. NAME LAST FIRST MIDDLE <b>GARCIA, ANTHONY J.</b>	2. DATE OF BIRTH ____/____/____	3. SOCIAL SECURITY NUMBER ____-____-____
4. ADDRESS STREET CITY STATE ZIP CODE _____ _____ _____ _____ _____	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.  <b>PHYSICIAN</b> <u>1 2 5</u> Profession Name Profession Code	
6. MARGEN OR GIVEN SURNAME _____		

**ADMINISTRATION:** Complete the remainder of this form and return it to the applicant.

A. HOSPITAL/INSTITUTION NAME <b>UNIVERSITY OF ILLINOIS-CHICAGO</b>	B. BEGINNING DATE <b>09.01.2001</b> Month Day Year	C. ENDING DATE <b>08.31.2004</b> Month Day Year
D. BUSINESS ADDRESS STREET CITY STATE ZIP CODE <b>914 S. WOOD ST., (MC 675) CHICAGO, IL 60612</b>	E. SPECIALTY/RESIDENCY NAME <b>PATHOLOGY</b>	
F. BUSINESS TELEPHONE NUMBER  Area Code ( <b>312</b> ) <b>996-2933</b>	G. YEAR OF POSTGRADUATE TRAINING <b>2</b>	

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure.

**RECEIVED**

**AUG 27 2001**

**IDPR-MEDICAL UNIT**



Signature of Program Director

**WELLINGTON JAO, M.D.**

Print Name of Program Director

**PROGRAM DIRECTOR**

Title

**8/13/01**

Date



STATE OF ILLINOIS  
DEPARTMENT OF PROFESSIONAL REGULATION

September 12, 2001

Anthony Joseph Garcia MD  
[REDACTED]

Dear Dr. Garcia:

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 09/01/2001. Assuming you remain in the training program listed below, this license will be valid until 08/31/2004.

PROGRAM: Pathology Training  
TRAINING FACILITY: Univ of Ill @ Chgo Hosp

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program, i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of the temporary license. Any violation of that Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62756.

Alicia Purchase, Manager  
Medical Unit

PC: lv3 125



# TEMPORARY CHECKLIST 125 130

## APPLICATION FINDINGS

☒ Application Complete  
☒ Personal History Year

### CA-MED(125)

Start Date: 9-1-01

End Date: 8-31-04

Program: Pathology

CA-LTD(130) - Illinois Program

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Program: \_\_\_\_\_

CA-MED(130) - Out-of-State Program

## DOMESTIC GRADUATES

ED-MED or Roster Date \_\_\_\_\_

Medical Transcripts \_\_\_\_\_

## FOREIGN GRADUATES

ECFMG/5th Pathway/Social Service \_\_\_\_\_

Premedical Transcripts \_\_\_\_\_ Translations \_\_\_\_\_

Medical Transcripts \_\_\_\_\_ Translations \_\_\_\_\_

Diploma Date \_\_\_\_\_ Translation \_\_\_\_\_

AF-MED Part A \_\_\_\_\_

AF-MED Part B \_\_\_\_\_

INTERNAL MED: Evaluation \_\_\_\_\_

Hospital: \_\_\_\_\_

Agreement \_\_\_\_\_

Affidavits: Hospital \_\_\_\_\_ School \_\_\_\_\_

PEDIATRICS: Evaluation \_\_\_\_\_

Hospital: \_\_\_\_\_

Agreement \_\_\_\_\_

Affidavits: Hospital \_\_\_\_\_ School \_\_\_\_\_

SURGERY: Evaluation \_\_\_\_\_

Hospital: \_\_\_\_\_

Agreement \_\_\_\_\_

Affidavits: Hospital \_\_\_\_\_ School \_\_\_\_\_

ED-NON \_\_\_\_\_ Total months - must be minimum of 36 w/premed; 54 combined

Minimum 4-weeks in Core Rotations: \_\_\_\_\_ Med \_\_\_\_\_ Ob/Gyn \_\_\_\_\_ Peds \_\_\_\_\_ Psych \_\_\_\_\_ Surgery \_\_\_\_\_

Psychiatry Affidavit if only 2-weeks verified \_\_\_\_\_

## SUPPORTING DOCUMENTS

☒ Work History \_\_\_\_\_ Clinical Skills OK ☒

☒ Original Jurisdiction of Licensure \_\_\_\_\_

License State & Number 4214 - Nebraska No Discipline ☒

☒ Current Jurisdiction of Licensure \_\_\_\_\_

License State & Number \_\_\_\_\_ No Discipline \_\_\_\_\_

☒ Name Change \_\_\_\_\_

☒ Federation Check \_\_\_\_\_

## PERSONAL HISTORY DOCUMENTS

UNIVERSITY OF ILLINOIS  
HOSPITAL/CHICAGO

Dept of GME

914 South Wood Street MC 675

Chicago 60612

Phone: 312/996-1066

☒ Premedical Transcripts

☒ Diploma Date 5-22-99

#125-043786  
Approved 9-12-04

236105

*[Signature]*

Profession: 105  
 Date: 8-8-01 Initials: J.F.

# DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO: Anthony J. Garcia, MD

Return this form with the requested materials to:  
 State of Illinois  
 Department of Professional Regulation  
 320 West Washington Street  
 MED 1  
 Springfield, Illinois 62786

1. Submit the required fee of \$_____ made payable to the Department of Professional Regulation. This fee is not refundable.	21. Complete AF-MED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
2. Your application is being returned for completion of Part _____	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WM).
5. Submit proof that you are a lawfully admitted alien.	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
7. When your application is complete, the Medical Licensing Board will review your qualifications.	28. Have your _____ scores forwarded directly from _____
8. Your application will be reviewed by the Medical Licensing Board on _____	29. Submit evidence of remedial training.
<input checked="" type="checkbox"/> 9. Submit completed CA-MED form which indicates beginning and ending program dates.	30. Submit TM-MED form signed by program director, with seal of hospital.
10. Submit CA-LTD form.	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationery must be attached verifying no seal exists.)
<input checked="" type="checkbox"/> 11. Submit ED-MED form (certification of education).	32. Sign form(s) where indicated.
12. Submit ED-MOM form completed in its entirety.	33. Submit certification of original/current licensure (Supporting Document CT) from <u>Nebraska</u>
13. Affidavits (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.	34. Submit proof that you are Board-certified in a specialty.
<input checked="" type="checkbox"/> 14. Verification of Pass/Fail Exam History—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	35. Submit restoration questionnaire (Supporting Document RS).
<input checked="" type="checkbox"/> 15. Submit official premedical/medical transcript with school seal affixed.	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
<input checked="" type="checkbox"/> 16. Submit photocopy of your degree.	37. Returning original documents.
17. Submit proof of Title or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____	

Other Instructions:



09/06/91

# UNIVERSITY OF UTAH

SALT LAKE CITY, UTAH 84142

PAGE 01

ACADEMIC RECORD OF  
NAME: GARCIA, ANTHONY JOSEPH  
SSN: [REDACTED]

DEGREE AWARDED BY OTHER INSTITUTIONS  
JUN BACHELOR-SCIENCE  
1994 CALIFORNIA STATE UNIV LOS ANGELES  
1994 LOS ANGELES, CA  
US

CUMULATIVE UNIVERSITY OF UTAH GPA 2.26  
UNIVERSITY OF UTAH COURSE UNITS PASSED 226.0  
U OF U UNITS IN CUMULATIVE GPA CALCULATION 226.0  
TOTAL UNITS PASSED (INCLUDING TRANSFER CREDIT  
SPECIAL EXAM, ETC) 226.0

COURSE TITLE DEPT CRSE LE UNIT GR

BEGINNING OF GRADUATE ACADEMIC RECORD \*\*\*\*\*

GROSS ANATOMY HUMAN ANAT 601  
HISTOLOGY ANAT 603  
EMBRYOLOGY ANAT 606  
MEDICAL BIOCHEMISTRY BIO C 608

QUARTER UNITS PASSED 24.0 TERM GPA

MEDICAL BIOCHEMISTRY BIO C 609  
MEDICINE & SOCIETY EP MD 634  
MEDICAL PHYSIOLOGY PHYSI 603  
BASIC SCI FOUNDATION PSYCH 601

QUARTER UNITS PASSED 13.0 TERM GPA

MEDICAL BIOCHEMISTRY BIO C 610  
GENETICS IN MEDICINE H GEN 610  
ENDOCRINOLOGY PHYSI 604

CONTINUED NEXT COLUMN

QUARTER UNITS PASSED 6.0 TERM GPA 0.00

CPR RECERTIFICATION AUTUMN 1995  
MEDICAL IMMUNOLOGY PATH 600  
MEDICAL MICROBIOLOGY PATH 604

QUARTER UNITS PASSED 5.0 TERM GPA 0.00

NEUROANATOMY ANAT 605  
INTRO TO MEDICINE INTMD 701

QUARTER UNITS PASSED 10.0 TERM GPA 0.00

INTRO TO MEDICINE INTMD 702  
GENERAL PATHOLOGY PATH 601  
PHARMACOLOGY THERAPY PH TX 601

QUARTER UNITS PASSED 13.0 TERM GPA 0.00

ORGAN SYSTEMS INTD 603  
SYSTEMIC PATHOLOGY PATH 602  
PHARMACOLOGY PH TX 604

QUARTER UNITS PASSED 23.0 TERM GPA 0.00

FOUNDATIONS GERIATRICS INTMD 703  
ORGAN SYSTEMS INTD 603  
SYSTEMIC PATHOLOGY PATH 602  
INTRO CLINICAL PSYCHIATRY PSYCH 610

QUARTER UNITS PASSED 21.0 TERM GPA 0.00

CONTINUED PAGE 02

GARCIA, ANTHONY JOSEPH  
ISSUED TO STUDENT



THE UNIVERSITY OF UTAH  
SALT LAKE CITY, UTAH 84142  
OFFICE OF THE REGISTRAR  
100 SOUTH 1400 EAST  
SALT LAKE CITY, UTAH 84143-2090  
TEL: 801/581-5500  
FAX: 801/581-5501  
WWW.UUTAH.EDU



UNIVERSITY OF UTAH  
SALT LAKE CITY, UTAH 84142

05/02/99

ISSUED TO STUDENT

ACADEMIC RECORD OF  
NAME: GARCIA, ANTHONY JOSEPH  
SSN: [REDACTED]

CONTINUED FROM PAGE 01

COURSE TITLE DEPT. CREDIT

CLINICAL OB GYN CLINIC 0857 701  
PEDIATRIC CLINIC 0857 701

QUARTER UNITS PASSED 34.0 TERM GPA 0.00

WINTER 1998  
CLINICAL OBSERVATION 1200 720  
TOPICS IN MEDICINE 1200 716  
PEDIATRIC CLINIC 1200 720

QUARTER UNITS PASSED 39.0 TERM GPA 0.00

SPRING 1998  
PRACTICE CLINIC 1200 718  
TOPICS IN MEDICINE 1200 715  
JUNIOR CLINICAL CLINIC 1200 702

QUARTER UNITS PASSED 27.0 TERM GPA 0.30  
END OF ACADEMIC RECORD

GARCIA, ANTHONY JOSEPH  
ISSUED TO STUDENT



UNIVERSITY OF UTAH  
SALT LAKE CITY, UTAH 84142  
OFFICE OF THE REGISTRAR  
100 SOUTH 1400 EAST  
SALT LAKE CITY, UTAH 84142  
PHONE (801) 524-2000  
FAX (801) 524-2001  
WWW.UUTAH.EDU



# UNIVERSITY OF UTAH

OFFICE OF THE REGISTRAR

ISSUED TO STUDENT



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# The University of Utah

upon the recommendation of the Faculty of

## The School of Medicine

has conferred upon

Anthony Joseph Garcia

the Degree of

## Doctor of Medicine

with all its Rights, Honors and Responsibilities

In Witness Whereof we have caused the Seal of the University to be affixed this

Twenty-second day of May, One Thousand Nine Hundred Ninety-nine.



President of the University

Chancellor

Dean of the Faculty of Medicine

Committee of Higher Education

Chairman, Board of Regents



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# WORK HISTORY

SUPPORTING DOCUMENT

# WH

**APPLICANT:** Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME LAST FIRST MIDDLE <u>Garcia, Anthony Joseph</u>		2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ADDRESS STREET CITY STATE ZIP CODE		5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <u>Physician</u> <u>125</u> Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME <u>N/A</u>		7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. <input type="checkbox"/>	8. DATE FORM COMPLETED <u>7-18-2001</u>

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS/INSTITUTION <u>Creighton University</u>		JOB TITLE <u>Physician</u>	
ADDRESS STREET CITY STATE ZIP CODE <u>601 N. 30th St. Omaha, NE. 68131</u>		DESCRIPTION OF DUTIES PERFORMED <u>Anatomic and clinical Pathology Study Pathology Study Medicine Job seeking</u>	
SUPERVISOR NAME <u>William Hunter</u>			
DATE OF EMPLOYMENT/ATTENDANCE From <u>07/01/2000</u> Month Day Year		HOURS WORKED PER WEEK <u>80</u>	
To <u>07/31/2001</u> Month Day Year		TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
TOTAL TIME WORKED (Year/Month) <u>1 year</u>			
B. NAME OF BUSINESS/INSTITUTION <u>Anthony Garcia</u>		JOB TITLE <u>Physician / Studier</u>	
ADDRESS STREET CITY STATE ZIP CODE		DESCRIPTION OF DUTIES PERFORMED <u>Study for USMLE step3 Study Pathology Study Medicine Job seeking</u>	
SUPERVISOR NAME <u>Anthony Garcia</u>			
DATE OF EMPLOYMENT/ATTENDANCE From <u>05/23/1999</u> Month Day Year		HOURS WORKED PER WEEK <u>80</u>	
To <u>06/30/2000</u> Month Day Year		TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
TOTAL TIME WORKED (Year/Month) <u>1 year 1 month</u>			

NAME (Last, First MI)

Garcia, Anthony, J.

SSN

Profession

Physician

**PART III - CERTIFICATION OF EXAMINATION SCORES****A1 National or other Profession Specific Examination**  
(Record all available information)

Date of Examination \_\_\_\_\_

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

**A2**

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

**B State Constructed Examination**

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

**PART IV - FORMAL ACTIONS****A** Is there now or has there ever been any formal action commenced against the applicant? Yes ☐ No ☐**B** Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.) ☐ Yes ☐ No**PART V - RECIPROCAL REGISTRATION**This state ☐ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State. I

**SEAL**\_\_\_\_\_  
Print Name\_\_\_\_\_  
Title\_\_\_\_\_  
Agency/Board Street Address\_\_\_\_\_  
City, State, ZIP Code\_\_\_\_\_  
Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Area Code ( )\_\_\_\_\_  
Telephone Number**RETURN NONEXAM CT TO:** Department of Professional Regulation  
320 West Washington, L & T-1  
Springfield, Illinois 62786



**CERTIFICATION OF LICENSE**

State of Illinois  
Dept of Professional Regulation  
320 W. Washington St  
Springfield IL 62786

<b>PROFESSION NAME:</b> Temporary Educational Permit	
<b>Number:</b> 4214	<b>Status:</b> Active
<b>Issuance Date:</b> 07/01/2000	<b>Expiration Date:</b> 07/01/2002
<b>Name:</b> Anthony Joseph Garcia MD	
<b>Address:</b> Creighton - Pathology	
<b>Credential Obtained by:</b> Application	
<b>School/Graduation Date:</b> Univ of Utah School of Med - Salt Lake City	09/22/1999
<b>Date of Birth:</b>	
<b>Place of Birth:</b> California	
<b>Disciplinary Action:</b>	

To expedite the certification process, the Credentialing Division is using the above format. There is no derogatory information in the professional's records if the Disciplinary Action section above is left blank.

**RECEIVED**

**AUG 31 2001**

**IDPR-MEDICAL UNIT**

Helen L. Meeks, Administrator  
Credentialing Division

August 28, 2001

(SEAL)

You may verify licenses under the following Internet Web Site Address:  
<http://www.hhs.state.ne.us/lis/lis.asp>

DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION AND LICENSURE  
PO Box 95007, LINCOLN, NE 68509-5007 PHONE (402) 471-2133

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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The Federation of State Medical Boards  
of the United States, Inc.  
Federal Plaza  
400 Euler Way, Suite 100  
Dallas, Texas 75201-3855  
Telephone: (817)868-4000  
FAX: (817)868-4099

## BOARD ACTION CLEARANCE REPORT

August 07, 2001

Attn: Alicia Purchase  
Illinois Dept. of Reg. & Ed.  
320 W. Washington Street  
Springfield, IL 62786

Re: Board Action Query Dated: August 07, 2001  
Your Reference Number:  
FSMB Batch Number:

The following is a final report of the search results from the Board Action Data Bank as of August 07, 2001 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of August 07, 2001

Item	Name	DOB	SSN	School	Yr/Grad	Request ID
6	DACANAY, KAREN			748070	1998	
6	GARCIA, ANTHONY			045010	1999	
6	GOODMAN, KATHY			099020	1987	
9	MELAMED, HOOMAN			039070	1999	
1	PANNARALLA, AMY			016020	1998	
4	STEPHEN, CATHLYN			014060	1987	
5	THOMAS, ANDREA			099660	2000	



0083107 00282 (40 40)

CREDENTIALING DIVISION

JUL 19 2001

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SUPPORTING DOCUMENT

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

**CERTIFICATION BY LICENSING AGENCY / BOARD**

**CT**

**APPLICANT:** Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE <u>Garcia, Anthony Joseph</u>		2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ADDRESS STREET, CITY, STATE, ZIP CODE <u>N/A.</u>		5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <u>Physician</u> <u>125</u> Profession Name Profession Code	
6. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)		7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code ( )	8. LICENSE NUMBER (If applicable) <u>4214</u>
9a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)		9b. ISSUANCE DATE OF LICENSE (If applicable) <u>07/01/2000</u>	
I hereby authorize <u>Dept. of Health and Human Services</u> to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below. Name of Licensing Agency or Board Signature <u>- M.D.</u> Date <u>7-18-2001</u>			

**DO NOT RETURN COMPLETED FORM TO APPLICANT**  
**LICENSING AGENCY:** The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

**PART I - CERTIFICATION OF EXAMINATION STATUS**

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

Name of Examination

B. The applicant has or will have written the above-named examination \_\_\_\_\_ Date of Examination \_\_\_\_\_ number of times.

**PART II - CERTIFICATION OF LICENSURE**

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE

B. LICENSE NUMBER

C. ISSUANCE DATE OF LICENSE

D. EXPIRATION DATE OF LICENSE

**E. LICENSURE METHOD**

☐ Examination (Administered in Your State)

☐ National (Name)

☐ State Constructed

☐ Other (Name)

☐ Endorsement of License (State)

Acceptance of Examination Results

(Administered in Another State)

☐ Reciprocity with (State)

☐ Waiver/Grandfather

☐ Credentials

☐ Other (Describe)

**F. CURRENT LICENSURE STATUS**

☐ Active

☐ Inactive

☐ Lapsed

☐ Other (Explain)

**G. IF LICENSED BY EXAMINATION, RECORD SCORES**

Type of Examination

Written

Practical

Other (Describe)

Score

Received no Grade Below

Examination Period \_\_\_\_\_ days \_\_\_\_\_ hours

CALIFORNIA STATE UNIVERSITY, LOS ANGELES  
5151 STATE UNIVERSITY DRIVE, LOS ANGELES, CA 90032

Anthony J. Garcia

Student ID: Birthdate:

Official Baccalaureate Academic Record

Secondary Schools:  
High School Graduation Date: Graduated Jun 1991  
Higher Education Institutions:  
UC Davis Sep 1983 - Dec 1993  
CSU Los Angeles Jun 1992 - Sep 1993  
Mt San Antonio College Jun 1988 - Jun 1992  
CSU Cal Poly Pomona Jan 1991 - Jun 1992  
Prelim Last '90

Degrees Awarded:  
Bachelor of Science  
School of Natural & Social Sciences  
Major: Biology  
Jun 11, 1994

Transfer Credit:  
HIGHER EDUCATION CREDIT: 136.00  
BIOL-418 EVOLUTION Summer Quarter 1992  
BIOL-499 UNDERGRD DIR STUDY Credit/No Credit

	AHRS	EHRS	QHRS
Current	8.00	8.00	4.00
Cumulative	144.00	144.00	4.00
BIOL-360 GENERAL ECOLOGY			
BIOL-398 COOP EDUC			

Credit/No Credit  
QUANT ANALYSIS  
CHEM-301A ORGANIC CHEMISTRY  
SDC-425 MEDICAL SOCIOLOGY

	AHRS	EHRS	QHRS
Current	16.00	16.00	16.00
Cumulative	162.00	162.00	20.00
BIOL-330 CELL BIOLOGY			
BIOL-357 WRITING FOR BIOL COOP EDUC			
BIOL-398			
BIOL-416 MOLECULAR GENETICS			
CHEM-301B ORGANIC CHEMISTRY			
CHEM-302A ORGANIC CHEM LAB			

	AHRS	EHRS	QHRS
Current	18.00	18.00	17.00
Cumulative	180.00	180.00	37.00

NO ENTRY BELOW THIS LINE

001022200

Transfer Credit Applied to Spring Quarter 1993  
SUPPLEMENTAL HIGHER ED CREDIT 12.00

	AHRS	EHRS	QHRS
BIOL-422 VETERINARY STRUCT-FUNCT			
BIOL-424 GEN EMBRYOLOGY			
BIOL-440 TAXON ANGIOSPERMS			
CHEM-301C ORGANIC CHEMISTRY			
CHEM-302B ORGANIC CHEM LAB			
MATH-206 CALCULUS I			

Advanced Placement

	AHRS	EHRS	QHRS
Current	22.00	22.00	18.00
Cumulative	214.00	214.00	55.00
NURS-300 PHYSIO+NUTR BASES OF FITNESS			
RELS-345 HLTH+WELLNESS WORLD RELIGIONS			

	AHRS	EHRS	QHRS
Current	8.00	8.00	8.00
Cumulative	222.00	222.00	63.00

Requirements completed for Bachelor of Science  
End of Baccalaureate Academic Record

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED, PROHIBITS RELEASE OF THIS TRANSCRIPT INFORMATION TO A THIRD PARTY WITHOUT WRITTEN CONSENT OF THE STUDENT.

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1269/12

Anthony Joseph Garcia

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09-05-01  
OFFICIAL  
ACADEMIC RECORD



CALIFORNIA STATE UNIVERSITY, LOS ANGELES  
5151 STATE UNIVERSITY DRIVE, LOS ANGELES, CA 90032

Anthony J. Garcia

Student ID: [REDACTED]

Birthdate: [REDACTED]

# Official Baccalaureate Academic Record

## Secondary Schools:

High School Graduation Date: [REDACTED]

## Higher Education Institutions:

UC Davis  
CSU Los Angeles  
Mt San Antonio College  
CSU Cal Poly Pomona  
Prelim Last 90

## Degrees Awarded:

Bachelor of Science  
School of Natural & Social Sciences  
Major: Biology

## Transfer Credits:

HIGHER EDUCATION CREDIT: 136.00

B10L-618 EVOLUTION  
B10L-699 UNDERGRAD STUDY  
Credit/No Credit

Current AHS EHS QHRS  
Cumulative 144.00 144.00 4.00

B10L-360 GENERAL ECOLOGY  
B10L-398 COOP EDUC

Credit/No Credit  
CHEM-201 QUANT ANALYSIS  
CHEM-301A ORGANIC CHEMISTRY  
SDC-425 MEDICAL SOCIOLOGY

Current AHS EHS QHRS  
Cumulative 162.00 162.00 20.00

B10L-330 CELL BIOLOGY  
B10L-357 WRITING FOR B10L  
B10L-398 COOP EDUC

Credit/No Credit  
B10L-416 MOLECULAR GENETICS  
CHEM-301B ORGANIC CHEMISTRY  
CHEM-302A ORGANIC CHEM LAB

Current AHS EHS QHRS  
Cumulative 180.00 180.00 17.00

Transfer Credit Applied to Spring Quarter 1993  
SUPPLEMENTAL HIGHER ED CREDIT 12.00

B10L-422 VERTEBRATE STRUCTURE/FUNCT

B10L-424 GEN EMBRYOLOGY  
B10L-470 TAXON ANGIOSPERMS  
CHEM-301C ORGANIC CHEMISTRY  
CHEM-302B ORGANIC CHEM LAB  
MATH-206 CALCULUS I

Advanced Placement

Current AHS EHS QHRS  
Cumulative 216.00 216.00 55.00

NIRS-300 PHYSTO+NUTR BASES OF FITNESS  
RELS-345 HEALTH+WELLNESS+WORLD RELIGIONS

Current AHS EHS QHRS  
Cumulative 222.00 222.00 63.00

Requirements completed for Bachelor of Science  
End of Baccalaureate Academic Record

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Anthony Joseph Garabaris, ms

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ACADEMIC RECORD

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